STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013613	A. BUILDING: _____ B. WING _____	R 10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS DEMENTIA CARE INC	**4301 WASHINGTON AVE EVANSVILLE, IN 47714**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the PSR completed on 7/17/15 to the Initial State Residential Licensure Survey completed on 4/28/15. Survey date: October 26, 2015 Facility Number: 013613 Provider Number: N/A AIM Number: N/A Census Bed Type: Residential: 10 Total: 10 Sample: 6 Oasis Dementia Care, Inc., was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the PSR to the Initial State Residential Licensure Survey. Quality review completed by #02748 on October 29, 2015.	{R 000}		